

24 March 2005

Original: English

Fifty-ninth session

Agenda item 43

**Follow-up to the outcome of the twenty-sixth special
session: implementation of the Declaration of
Commitment on HIV/AIDS**

High-level meeting on HIV/AIDS

**Discussion paper for the round table on orphans and children
made vulnerable by HIV/AIDS, to be convened by the
United Nations Children's Fund and the World Food Programme**

Summary

The present paper is aimed at stimulating discussions in the round table and should be read in conjunction with the forthcoming report of the Secretary-General on progress towards implementation of the Declaration of Commitment on HIV/AIDS.

A summary of the discussions, which are expected to be lively, open and interactive, will be conveyed to the High-level Plenary Meeting of the sixtieth session of the General Assembly in September 2005 so that it may undertake a comprehensive review of the progress made in the fulfilment of the commitments contained in the United Nations Millennium Declaration, including the internationally agreed development goals, and of the progress made in the integrated and coordinated implementation and follow-up to the outcomes of the major United Nations conferences and summits in the economic, social and related fields.



1. Poverty, conflict and HIV/AIDS are undermining childhood in a way that is devastating and long lasting for individual children and their families.¹ The impact of HIV/AIDS is large and growing and, despite the increase in funds allocated to HIV/AIDS programmes over the past few years, massively underresourced. Without addressing the fundamental factors that threaten, marginalize and kill children, we will not reach the Millennium Development Goals, the 2001 Declaration of Commitment on HIV/AIDS adopted by the General Assembly at its twenty-sixth special session, the goals on HIV/AIDS outlined in a World Fit for Children or ensure the protection of the rights enshrined in the Convention of the Rights of the Child.

2. The response for children and AIDS should take into consideration a number of issues.

I. Defining vulnerability: re-examining the evidence

3. As more studies are conducted and evidence emerges, the validity of factors once thought to be likely to determine the vulnerability of households and, specifically, the children in those households are being questioned. Recent evidence from southern Africa dispels some previous assumptions. For instance, it was thought that households caring for orphans or families with high dependency ratios (i.e., with many children and elderly family members who are supported by few productive adults) were those most likely to experience food insecurity. Data from the community household survey carried out by the Consortium for Southern Africa Food Security Emergency (C-SAFE) and the World Food Programme (WFP) show that a lack of assets is a much greater determinant of households in need. Moreover, this six-country data set, conducted in two rounds over two years, shows that the presence of a chronically ill person is much more important as a factor of food insecurity than the presence of orphans. In other words, the presence of orphans does not automatically mean household vulnerability.

4. We also now know that the impact of HIV/AIDS on children extends beyond those who are orphaned. A number of studies have shown that children who are living in households with sick or dying parents are often more vulnerable, disadvantaged, malnourished and less likely to go to school than children who have actually lost their parents. A small survey in Blantyre, Malawi, found that children with a chronically ill parent or adult in the household, or who had recently experienced the death of an adult in the household, are less likely to have basic material needs and are more likely to be in households that lacked adequate food.

5. In southern Africa, WFP and C-SAFE are working together to assess and analyse vulnerability characteristics within vulnerable populations. To date, consolidated data analysis has not been able to identify significantly different conditions for orphans and orphan-hosting families. In future analysis, further disaggregation of the data by type of orphanhood and relation to the head of household may provide more detailed insights.

6. More work is needed in defining which children are vulnerable, when they are most vulnerable, what kinds of services they need and at what stage they need them. How can we work together to test assumptions and widely held myths about the impact of AIDS on children's vulnerability and dispel them in order to improve the delivery of services for vulnerable children?

II. Making education accessible

7. HIV/AIDS is having a tremendous impact on children's access to education. As Governments and donors seek to improve education systems so that all children can go to school, they must consider the special vulnerabilities of children affected by HIV/AIDS and the particular obstacles that children from households affected by HIV/AIDS face in getting an education. We need to start collecting data not only on children who have been orphaned, but also those who are in households with chronically ill or dying parents. We need to understand how to reach children who are out of school and especially how to reintegrate back into the classroom those who have dropped out because of illness or the death of a parent.

8. Additional food in the form of take-home rations can also be directed to children affected by AIDS who are attending school. They provide a benefit for HIV/AIDS-affected households that do not have enough to eat. These kinds of programmes make it possible for caregivers to send children — girls in particular — to school instead of requiring the child to work for additional household income. In addition, it is important to recognize that children may in many cases be the primary caregivers for their ill parents and grandparents. The duties they perform are a reality that cannot be ignored. While ensuring universal access to primary education is the goal, in situations where that is not possible in the short term, children need direct support and skills training in addition to psychosocial support.

9. **Children's access to schools is hampered by financial costs and the need to fill productive roles at home. How can we work together to design realistic programmes that benefit the most vulnerable children and not lapse into traditional responses that ignore the hardships and realities faced by those same children we aim to serve?**

III. Maximizing the protective effect of education

10. It is clear that a strong investment made in the education sector will have a great impact on the chances of the next generation remaining HIV-free. Indeed, structuring school systems in a way that ensures access for affected children is likely to promote enrolment for all vulnerable children. Ensuring school access, including through the abolition of school fees and the provision of school meal programmes, must be a priority. According to the recently released *Report of the Commission for Africa: our common interest* (2005), the removal of school fees would help girls in particular, as would school meals and school attendance grants. Removing school fees in Uganda almost doubled the number of very poor girls in school. According to the WFP school feeding survey in 2004, providing additional take-home rations for girls can improve attendance and result in dramatic increases of over 30 per cent in school enrolment. The proven cost-effectiveness of school feeding programmes, at just 19 cents a day, promises not only to be a way to ensure the education of vulnerable children but also to be an efficient model to achieve desired scalability. Governments need to plan more systematically for measures that will achieve greater educational equality for girls.

11. While no one disputes the need to increase efforts around universal primary education, the current emphasis on primary education may be too limiting as far as reaping the benefits of education is concerned, especially for adolescent girls.

According to the World Bank (2002), education can protect women in particular from HIV infection by providing knowledge that has a long-term impact on their behaviour. Education reduces the social and economic vulnerability that exposes women to a higher risk of HIV/AIDS than men, including the need to engage in sex work or other forms of economic dependence on men. Schools not only provide education, knowledge and life skills that help young people to avoid HIV, they can encourage communities to form groups that also promote prevention (Gregson and Terceira, 2001). Importantly, further evidence for the protective effect of education can be found in Zimbabwe, where girls aged 15 to 18 years who dropped out of high school were six times more likely to be HIV-positive than those who were still enrolled (Gregson and Waddell, 2001); in Zambia, where there was a marked decline in HIV prevalence rates among adolescents aged 15 to 19 years with medium to high levels of education, but increased rates among those with lower educational levels (Kelly, 2000); and in Uganda, where rural youth with secondary education are three times less likely to contract HIV than those with no education (De Walque, 2004). All of these examples point to the need to focus on secondary education, especially for girls, if we want to have a real impact on the spread of the epidemic among young people.

IV. Monitoring the response

12. Despite the commitment made by Governments to ensure the well-being of children affected by AIDS at the special session of the General Assembly on HIV/AIDS in 2001, there is little data available to develop a baseline on their situation, which is necessary to evaluate the response.

13. However, an increasing number of Governments are conducting analyses and developing action plans. Sixteen countries in sub-Saharan Africa have accelerated national planning for children and AIDS through the rapid assessment, analysis and action planning process. Based on data collection and analysis using a set of standard tools, these countries are now in the final stages of action planning and developing monitoring and evaluation frameworks.

14. Indicators to measure the situation of children affected by AIDS can be difficult for a number of reasons. Countries vary in defining the children whose well-being needs to be monitored. Governments need to monitor the situation of orphans, as well as a subgroup of "vulnerable children". Defining this subgroup can be controversial as it may result in targeting the very children being monitored, which leads to poor programming practices and possibly increased stigma and discrimination. In addition, information from community-based organizations on the number of children receiving services is often poor. This leads to the risk that children are "double counted", thus hampering the measure of service coverage.

15. Countries must ensure that children in need are being reached and followed effectively through sound monitoring and evaluation systems. How can Governments hold themselves accountable for assessing, analysing and improving the situation of orphans and other children affected by HIV and AIDS pursuant to the commitments made by Governments in the Declaration of Commitment?

V. Framework for action

16. It is time to move beyond the wide endorsement of principles and strategies and into action-oriented responses. The *Framework for the Protection, Care and Support of Orphans and Vulnerable Children Living in a World with HIV and AIDS*² describes broad strategies that should underpin all quality responses for children affected by HIV and AIDS:

(a) Strengthen the capacity of families to protect and care for orphans and vulnerable children by prolonging the lives of parents and providing economic, psychosocial and other support;

(b) Mobilize and support community-based responses;

(c) Ensure access for orphans and vulnerable children to essential services, including education, health care and birth registration;

(d) Ensure that Governments protect the most vulnerable children through improved policy and legislation and by channelling resources to families and communities;

(e) Raise awareness at all levels through advocacy and social mobilization to create a supportive environment for children and families affected by HIV and AIDS.

17. Within these strategies, evidence on the specific and variable impacts of HIV/AIDS on children must guide programming and policy decisions. Particular emphasis is needed in priority areas, including: ensuring vulnerable households' food security and economic capacity, keeping HIV-positive parents healthy, enabling education, providing psychosocial support and strengthening capacity for monitoring and evaluation. These actions must be taken forward in support of Government-owned HIV/AIDS, sectoral and poverty-reduction plans.

18. A concerted effort by all is required to improve the situation of vulnerable, food insecure and AIDS-affected households. Strengthening the family's capacity to take care of itself is at the heart of an effective HIV/AIDS response. How can we work together to implement the Framework and strengthened partnerships across sectors that will reduce the impact of the epidemic on children?

VI. Maintaining and strengthening household capacity

19. Families and households are the first line of support for children affected by HIV and AIDS. Keeping children within family situations is dependent on the survival of the household. Programmes that contribute to the economic strengthening of vulnerable households help to ensure that children remain in the family, have access to food and education and contribute to the long-term survival of the household. Ensuring the legal protection of assets and inheritance intended for the child is also critical to preventing children from being deprived of many of their rights by being removed from parental care, separated from family and possessions and by becoming exposed to abuse and exploitation.

20. The best way to reduce AIDS-related vulnerability in children is to keep parents and caregivers HIV-free, and healthy if infected. The "three by five"

initiative led by the World Health Organization is crucial to reducing the vulnerability of children affected by AIDS. This means working in partnerships to expand access to care, support and treatment for parents, including through scaling up the comprehensive mother-to-child transmission plus initiative to prevent new infections in parents and infants, to prevent unintended pregnancy and to expand treatment access to families, especially the over 2 million children living with HIV/AIDS. Programmes that provide nutritional support help keep HIV-positive parents healthy for as long as possible. Community-based food and nutrition programmes are essential to ensuring the nutrition and education of the children in the family.

21. Children of all ages are vulnerable to the emotional stresses of losing caregivers and being dislocated from home and community. The long-term consequences for children who experience profound loss can include psychosomatic disorders, chronic depression, low self-esteem, inadequate life skills, learning disabilities and disturbed social behaviour.

22. Care and support for vulnerable children have tended to focus on meeting material needs; few programmes have addressed the psychosocial needs of children affected by AIDS. Communicating with children and gaining their trust is an important source of support for children and counselling assistance of this kind can be provided by trained non-professionals. Play and learning are important compensatory experiences for children and can assist children to recover from trauma and distress. Several approaches have been developed to train sensitive lay counsellors to give assistance to affected children and their families. Guardians, teachers, health workers, faith-based groups and youth volunteers can be trained to identify children's emotional needs and support children.

23. **There is a need to increase resources and interventions to ensure that children receive care and support, especially treatment for opportunistic diseases and antiretroviral therapy. How can we work together to ensure that programmes targeting children affected by AIDS address their comprehensive needs with both direct short-term support as well as longer-term strategies for survival?**

Notes

¹ United Nations Children's Fund, *The State of the World's Children 2005* (New York, 2004).

² UNICEF and partners, New York, 2004 (see www.unicef.org/aids/files/Framework_English.pdf).

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High-level meeting on HIV/AIDS

**Discussion paper for the round table on prevention to be
convened by the United Nations Population Fund, the
United Nations Educational, Scientific and Cultural
Organization and the United Nations Office on Drugs
and Crime**

Summary

The present paper is aimed at stimulating discussions in the round table and should be read in conjunction with the forthcoming report of the Secretary-General on progress towards implementation of the Declaration of Commitment on HIV/AIDS.

A summary of the discussions, which are expected to be lively, open and interactive, will be conveyed to the High-level Plenary Meeting of the sixtieth session of the General Assembly in September 2005 so that it may undertake a comprehensive review of the progress made in the fulfilment of the commitments contained in the United Nations Millennium Declaration, including the internationally agreed development goals, and of the progress made in the integrated and coordinated implementation and follow-up to the outcomes of the major United Nations conferences and summits in the economic, social and related fields.



1. Over 5 million new infections a year attest that collective world action to abate the HIV/AIDS epidemic has been insufficient. While prevention has long been heralded as the mainstay of the response, globally, fewer than one in five persons has access to basic HIV prevention programmes.¹ Large scale implementation of effective prevention remains hampered by social, cultural and leadership reluctance to deal with issues of sex, sexuality and high-risk behaviour: together with the continued preponderance of poverty, gender inequality and lack of respect for the universality of human rights that fuel the epidemic. It is critical that efforts focus on AIDS as both an emergency and a long-term development issue, thus acting simultaneously on individual behavioural change and on wider social, cultural and economic change.

I. Linking sexual and reproductive health and HIV/AIDS

2. With sexual transmission the source of over 75 per cent of HIV infections, sexual and reproductive health services is a clear strategic entry point for maximizing the impact of HIV prevention efforts. Recent reports by the United Nations Millennium Project² take these linkages further, supporting conclusions that ensuring access to sexual and reproductive health information and services, including voluntary family planning, is essential for achieving the Millennium Development Goals³ and that gender equality, essential in combating HIV, cannot be achieved without guaranteeing the reproductive rights of women and girls. Task Force 5 and its Working Group on HIV/AIDS of the Millennium Project also recommended that Governments incorporate universal access to reproductive and sexual health services as an integral part of their response to AIDS.⁴

3. In June 2004, a high-level global consultation reached similar conclusions, codified in the New York Call to Commitment: Linking HIV/AIDS and Sexual and Reproductive Health, which emphasizes that sexual and reproductive health and HIV/AIDS initiatives must be mutually reinforcing as HIV, AIDS, and sexual and reproductive ill-health are driven by many common root causes, including gender inequality, poverty and social marginalization of the most vulnerable populations. Strong linkages between sexual and reproductive health and HIV/AIDS will result in more relevant and cost-effective programmes with greater impact, utilizing existing infrastructure for delivering maternal health, management of sexually transmitted infections, family planning and community based outreach.

II. Prevention of mother-to-child transmission

4. Similarly the Glion Call to Action on Family Planning and HIV/AIDS in Women and Children (May 2004) focuses on preventing HIV among women and children, and linking family planning with prevention of mother-to-child transmission. Access to sexual and reproductive health services, including primary prevention in women and prevention of unintended pregnancies in women living with HIV, could decrease infection in children by 35 to 45 per cent in some countries.⁵ Thus, universal access to reproductive health⁶ is critical.

III. Women

5. The AIDS epidemic has insidiously taken a toll on women and adolescent girls, who account for nearly 50 per cent of all people living with HIV worldwide.⁷ Bearing the brunt of the epidemic's impact, they are most often the caregivers for the sick, the most likely to lose their income and school opportunities and the ones who often confront stigma and discrimination and who suffer from underlying issues such as unequal property and inheritance rights and poor livelihood opportunities, which increase their vulnerabilities. Young women are particularly hard hit, representing over 60 per cent of all 15 to 24-year-olds living with HIV.

6. To reverse this impact, broad-scale action must be taken in countries to ensure: (a) that adolescent girls and women have the knowledge and means to prevent HIV infection; (b) equal and universal access to treatment; (c) support for home-based caregivers of AIDS patients and orphans; (d) promotion of girls' primary and secondary education and women's literacy; (e) promotion of zero tolerance for all forms of violence against women and girls; and (f) promotion and protection of the human rights of women and girls. Engaging civil society and other partners, such as the Global Coalition on Women and AIDS, a broad-based coalition aiming to stimulate concrete actions and lessen the devastating impact of AIDS on women and girls, must continue.

IV. Young people

7. The goals and targets of the twenty-sixth special session of the General Assembly provide a focus for national efforts to prevent HIV infections among young people by enabling them to adopt attitudes and behaviours that decrease their risk of infection and by ensuring that the environments in which they live, including social values and norms, support and do not undermine young people's ability to protect themselves from HIV. It is a major challenge to reach the over one billion adolescents now entering sexual maturity with the information, education, and health services they urgently need to protect themselves from HIV. The importance of such protection is even more urgent since, in many countries, large numbers of young people become sexually active while in their teens. Too often, however, young people are overlooked or discriminated against, and services are inaccessible or legally withheld until it is too late. Despite all the risks young people face, the information, education and services provided to them are woefully inadequate and engagement of key sectors such as education is often poor. With an estimated 5,000 to 6,000 young people becoming infected daily, in some regions constituting a significant percentage of high-risk populations, the needs of young people must be given the highest priority.

8. Education is a crucial and central element for enabling people to reduce both the risk of HIV infection and vulnerability to HIV/AIDS. Statistics show that the attainment of higher levels of education translates into the adoption of safer sexual behaviours (including deferred onset) and reduced vulnerability to HIV infection and other sexually transmitted infections, particularly for young girls. Yet universal primary education remains an illusive goal and the inclusion of HIV/AIDS in school curriculum does not guarantee that it will be taught. Commitments from the World Education Forum, held in Dakar in 2000, as well as targets contained in the Millennium Development Goals must be met.

9. In May 2004, a global consultation between the Joint United Nations Programme on HIV/AIDS (UNAIDS), research institutions, policy makers, programmers and funders reviewed the existing evidence base for interventions to achieve the global goals relating to HIV and young people. Interventions were allocated to "Steady", "Ready", "Go" categories. From the preliminary analysis, core interventions included: (a) skills-based sexual health education in schools, provided that the specified quality criteria for effective programmes are maintained; (b) youth-friendly health services offering core interventions for the prevention, diagnosis and treatment of sexually transmitted infections and HIV/AIDS; (c) interventions to prevent HIV transmission through unsafe drug injecting practices, and services targeted to other vulnerable groups at high risk; and (d) mass media interventions that are modeled on those media interventions that have demonstrable effectiveness and a dose-response effect. Conclusions confirmed that no single intervention can address the high HIV infection rates among young people. Young people are not a homogenous group and clearly require a range of interventions that address the diverse contexts in which they live, learn and earn.

V. Vulnerable populations

10. Individuals and groups that engage in high risk behaviour often experience heightened vulnerability due to marginalization, stigma and discrimination and economic and legal disempowerment. To prevent, halt and reverse epidemics among these groups requires interventions that both increase their access to prevention and care information and services and that address the root causes of their vulnerability.

11. One of the most contentious issues is that of HIV prevention among the 13.2 million injecting drug users worldwide. Government leaders must acknowledge their presence and risk of infection. HIV spreads rapidly among injecting drug users through the sharing of injecting equipment, compounded by poor access to drug dependence treatment and HIV prevention services. Their sexual partners can also become infected through unsafe sexual behaviour and their newborn children are frequently HIV-infected. In addition, drug injection along with tattooing and skin piercing, unsafe sexual behaviour and sexual violence create a high-risk environment for the 30 million who pass through prison in any given year.

12. Pilot projects are not the answer. Interventions are needed on a large scale to reach the majority of these populations and their families. Different government sectors (for example, health, justice, interior, police, education, finance and development planning) need to collaborate in a multidisciplinary team, including civil society organizations, to deliver needed services.

VI. Commodity security

13. In accordance with paragraph 52 of the Declaration of Commitment on HIV/AIDS, a wide range of prevention programmes should be made available yet major shortfalls remain for many elements. Condom programming, an integral component of HIV prevention strategies that include informed, responsible and safer sexual behaviour through abstinence, delayed age of onset of sexual activity, reduced number of sex partners and condom use, is one example. Critical messages need to be acknowledged and acted upon, including: (a) condoms are the single

most efficient available technology to reduce the sexual transmission of HIV and other sexually transmitted infections; (b) male and female condoms must be made readily available universally, either free or at low cost, and promoted in ways that help overcome social and personal obstacles to their use; (c) the complex gender and cultural obstacles to ensuring HIV prevention education and effective condom use must be overcome; (d) condoms play a decisive role in HIV prevention efforts in many countries especially those with concentrated epidemics and have also encouraged safer sexual behaviour more generally; and (e) increased access to voluntary counseling and testing and to antiretroviral treatment create the need and opportunity for accelerated condom promotion. In addition, the availability of sterile injecting equipment for injecting drug users in the context of comprehensive drug demand reduction can contribute significantly to reduce the rate of HIV transmission.

VII. World of work

14. The workplace is an excellent place to introduce HIV prevention programmes. Programmes reach employees, their families and communities and other key stakeholders, providing information on both occupational and personal risk reduction and prevention as well as for forging vital links between different sections of the population and between different interest groups. The workplace offers an important forum for: encouraging the elimination of stigma and discrimination; using different approaches to improve HIV prevention through practical, sustainable and effective interventions that result in changes in attitudes and personal behaviours; and facilitating and supporting these changes through initiatives that reach workers and their families.

15. Practical measures must be undertaken to ensure the success and coordination of workplace programmes, including: implementation of national and international strategies; infrastructure development; regulatory frameworks; technical capacity and support; media communications; mobilization of stakeholders (including young people), organizations and resources.

VIII. Emergencies

16. People in emergency situations, especially refugee populations, have a range of needs that are important for survival, health and well-being. As traditional supports collapse, the danger of HIV transmission increases. Desperate for food and shelter, resident populations and those who have been displaced can be forced to adopt risky behavioural practices. Sexual exploitation and abuse also occur more frequently. Programmes that integrate key actions in HIV/AIDS, as outlined in the guidelines of the Inter-Agency Standing Committee Task Force on HIV/AIDS in Emergency Settings, such as food security interventions, are effective means of preventing the spread of HIV.

IX. Migrant and mobile worker populations

17. It is the situations faced in migration, in particular poverty, exploitation, and separation from families and partners, that put migrants and mobile workers at risk

of HIV infection. There is an increasing awareness that migrants often live in situations where they are more vulnerable to HIV than local populations, and are at risk of spreading the infection upon their return in communities and countries of origin, often unwittingly. The heightened vulnerabilities of these populations to HIV must be addressed.

X. Continuum of prevention, treatment, care and support

18. Prevention, treatment, care and support efforts form a response continuum, including prevention by and for people living with HIV. The challenge of integrating prevention fully into treatment and care delivery must be met, as their effectiveness is vastly improved when they are utilized together. Without effective prevention, treatment will become increasingly unsustainable. It is essential to prioritize interventions with populations most at risk and to uphold the strategy of greater involvement of people living with HIV and AIDS, especially to ensure their full involvement in prevention efforts.

XI. Intensifying prevention

19. Low use of prevention interventions (for example less than 5 per cent among injecting drug users,⁸ 5 per cent for prevention of mother-to-child transmission of HIV and 42 per cent for condoms)⁹ reveals a critical coverage gap in the response. The fact that those most vulnerable to infection most often have no access to prevention should be a major cause for alarm. **Prevention is the best and most viable approach to reverse, and ultimately halt the epidemic and must remain the foundation of any response.** The same urgency that has been brought to bear on the drive to expand treatment access thus must also be brought to re-intensify HIV prevention. Key questions to consider include:

(a) How can synergy between prevention, treatment and care be maximized? Integration of sexual and reproductive health and HIV/AIDS may be one important answer;

(b) What are the key issues to overcome in order to effectively engage multiple ministries and groups in the national response? For example, how can broad engagement in education be motivated?

(c) How can nations expect sustainable progress against the epidemic without addressing underlying structural issues, including ensuring human rights, gender equality, women's empowerment and poverty reduction?

(d) Given the innate sensitivities, how can national action plans be enhanced to better meet the needs of the most vulnerable and ensure that programmes address populations engaged in high-risk behaviours? For example, can public-private partnerships be formed to take effective action on drug abuse prevention and drug dependence treatment programmes?

(e) How can we ensure that the vulnerability and risk levels among young people are acknowledged, understood and overcome? Better age disaggregated data collection might provide a starting point. Furthermore, how

can nations address young people's special needs and circumstances and respect their rights?

(f) How can nations better ensure the full involvement of civil society, young people, women, at-risk populations and people living with HIV and AIDS at all stages of the response from planning and implementation to monitoring and evaluation?

(g) How can monitoring and evaluation systems and capacities be strengthened to provide a stronger evidence base and enhance results in HIV prevention?

(h) How can nations best scale up prevention efforts? Building on evidence, informed interventions with proven impact will be an essential element, including the use of positive socio-cultural values and norms that encourage an environment of non-discrimination and destigmatization to open the door to effective prevention and care efforts.

20. There is increasing political commitment to fight HIV/AIDS within the world community, and funds are increasingly available. The synergies among prevention, care and treatment are understood, and there is a more clear understanding of effective and promising interventions. What is needed is a more rigorous upholding of the universality of human rights, including for young people, women and the most vulnerable populations, as well as greater action, building upon what works and linking existing infrastructures to ensure maximum coverage and impact.

Notes

¹ Global HIV Prevention Working Group, 2004, "HIV Prevention In The Era Of Expanded Treatment Access".

² United Nations Millennium Project, 2005, *Investing in Development: A Practical Plan to Achieve the Millennium Development Goals*, and multiple task force reports presented in January 2005.

³ The achievement of the goals and targets set out in the Declaration of Commitment on HIV/AIDS, adopted at the twenty-sixth special session of the General Assembly, contribute directly to the achievement of the Millennium Development Goals, particularly Goal 6: to halt and reverse the HIV/AIDS epidemic.

⁴ United Nations Millennium Project, 2005, *Combating AIDS in the Developing World*; Task Force 5 on HIV/AIDS, Malaria, TB, Other Major Diseases and Access to Essential Medicines, Working Group on HIV/AIDS.

⁵ The Glion Call to Action on Family Planning and HIV/AIDS in Women and Children, 3-5 May 2004.

⁶ As noted in the Programme of Action of the International Conference on Population and Development.

⁷ Joint United Nations Programme on HIV/AIDS (UNAIDS), 2004, *2004 Report on the global AIDS epidemic*. While prevalence rates among women and men vary among and within regions, the overall trend of infections in women is cause for alarm.

⁸ United Nations Office on Drugs and Crime.

⁹ Global HIV Prevention Working Group, 2004, "HIV Prevention In The Era Of Expanded Treatment Access".

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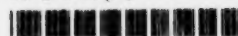
High-level meeting on HIV/AIDS

Discussion paper for the round table on human rights, gender and HIV/AIDS: to be convened by the United Nations Development Programme, the Office of the United Nations High Commissioner for Refugees, the United Nations Development Fund for Women and the Global Coalition on Women and AIDS

Summary

The present paper is aimed at stimulating discussions in the round table and should be read in conjunction with the forthcoming report of the Secretary-General on progress towards implementation of the Declaration of Commitment on HIV/AIDS.

A summary of the discussions, which are expected to be lively, open and interactive, will be conveyed to the High-level Plenary Meeting of the sixtieth session of the General Assembly in September 2005 so that it may undertake a comprehensive review of the progress made in the fulfilment of the commitments contained in the United Nations Millennium Declaration, including the internationally agreed development goals, and of the progress made in the integrated and coordinated implementation and follow-up to the outcomes of the major United Nations conferences and summits in the economic, social and related fields.



1. Human rights violations and inequitable gender relations continue to fuel the spread of the HIV/AIDS epidemic. Men and women often face social exclusion as a result of their HIV status, hindering efforts to address the epidemic openly and effectively. Violations of rights hamper access to prevention, treatment and support services for people living with HIV/AIDS and for marginalized populations, which are particularly vulnerable to infection, including injecting drug users, commercial sex workers and men who have sex with men. Human rights infringements, whether in families, communities, workplaces or health facilities, discourage people from speaking openly about HIV, seeking information and accessing support, treatment and legal services.
2. The number of women living with HIV/AIDS is rising worldwide, and more than 60 per cent of 15- to 24-year-olds living with HIV are young women. The growing feminization of the epidemic is a reflection of social, economic and legal inequities that increase the vulnerability of women and girls to infection. Lower social status, gender stereotypes, gender-based violence and reduced access to information, education and economic opportunities disempower women and limit their ability to negotiate safer sexual relations, thereby increasing risk to infection for both men and women. Women have been at the forefront of responding to HIV/AIDS in communities, and women and girls bear the burden of providing care and support in families and communities affected by AIDS, often at the cost of educational and economic opportunities.
3. Despite the tremendous efforts of governments to achieve the Millennium Development Goals, including Goal 3, "Promote gender equality and empower women" and Goal 6, "Combat HIV/AIDS, malaria and other diseases", gender inequality continues to fuel the spread of HIV/AIDS. It is clear that if the dual and synergistic challenges of gender equality and respect for human rights are not addressed, the achievement of the Millennium Development Goals and the targets of the Declaration of Commitment on HIV/AIDS will be jeopardized.

I. Human rights and gender targets in the Declaration of Commitment on HIV/AIDS

4. In signing the Declaration of Commitment on HIV/AIDS, Member States recognized the protection of human rights and promotion of gender equality as necessary components of an effective response to HIV/AIDS, affirming that: "the full realization of human rights and fundamental freedoms for all is an essential element in a global response to the HIV/AIDS pandemic", and that "gender equality and the empowerment of women are fundamental elements in the reduction of the vulnerability of women and girls to HIV/AIDS".
5. The Declaration highlights key human rights dimensions of the epidemic and sets targets that include confronting stigma and discrimination and ensuring the full participation of people living with HIV/AIDS, women and young people in the implementation of national HIV/AIDS plans. Human rights targets also focus on legislation to protect the rights and fundamental freedoms of people living with HIV/AIDS and vulnerable groups to ensure access to "education, inheritance, employment, health care, social and health services, prevention, support and treatment, information and legal protection, while respecting their privacy and confidentiality".

6. The Declaration also sets gender equality targets to be achieved by 2005 that address the disproportionate impact of HIV on women and girls, including the implementation of national strategies to "promote the advancement of women and women's full enjoyment of all human rights; promote shared responsibility of men and women to ensure safe sex; and empower women to have control over and decide freely and responsibly on matters related to their sexuality". The Declaration also sets targets for the provision of prevention education to promote gender equality, and increased access to health services, including sexual and reproductive health, for women and girls.

7. Further, the Declaration calls on countries to "ensure development and accelerated implementation of national strategies for women's empowerment, the promotion and protection of women's full enjoyment of all human rights and reduction of their vulnerability to HIV/AIDS through the elimination of all forms of discrimination, as well as all forms of violence against women and girls, including harmful traditional and customary practices, abuse, rape and other forms of sexual violence, battering and trafficking in women and girls" by 2005.

II. Progress in meeting human rights and gender targets

8. Since the adoption of the Declaration of Commitment on HIV/AIDS in 2001, progress in meeting human rights and gender targets has been disappointing. The report of the Secretary-General on the progress towards implementation of the Declaration of Commitment on HIV/AIDS (A/58/184) indicates that by 2003, nearly 40 per cent of all countries globally and almost half of those in sub-Saharan Africa had yet to adopt legislation to prevent stigma and discrimination against people living with HIV/AIDS. Moreover, few countries had adopted legislation to protect vulnerable populations from discrimination. The report highlights that, in four regions surveyed, an alarming 30 to 60 per cent of women report experiencing physical or sexual violence. In addition, across South Asia and sub-Saharan Africa, women often have limited rights to property and inheritance. National, regional and global initiatives, including the Global Coalition on Women and AIDS, have focused attention and developed strategies to address women's vulnerability and integrate gender into HIV/AIDS responses. These advances, however, need to be expanded and accelerated in order to effectively challenge the underlying causes of HIV and the spread of the epidemic.

III. Promoting key strategies to achieve human rights and gender targets

9. Despite increasing consensus on what needs to be done to meet human rights and gender targets, actions taken have not been sufficient. Responses to HIV/AIDS must apply a human rights framework and integrate gender equality concerns in order to reduce vulnerability to infection, advance prevention goals, provide equal access to treatment, care and support, and mitigate the social and economic impact of HIV/AIDS. The following strategies must guide the design, implementation and evaluation of HIV/AIDS responses at global, regional and national levels.

A. Protecting the rights of people

1. Promoting the rights of people living with HIV/AIDS

10. Stigma and discrimination against people living with HIV/AIDS and their families foster an environment of denial and silence. Protection of rights to education, employment, treatment and confidentiality for men and women living with HIV continues to be a key area for action. The challenge is to confront stigma and discrimination and create an enabling human rights environment for more open, inclusive and effective responses to the epidemic.

2. Protecting the rights of vulnerable populations

11. Groups that are marginalized or socially excluded face an increased risk of exposure to HIV infection. Failure to safeguard the rights of marginalized populations, including injecting drug users, commercial sex workers and men who have sex with men, and to provide them with HIV-related services perpetuates stigma and undermines prevention efforts. The challenge is to protect the rights of marginalized and vulnerable populations and ensure they are reached with information, prevention messages and services to limit the spread of HIV within groups and among the wider population.

3. Promoting equitable rights to property and inheritance

12. Inequitable property and inheritance rights disempower women, increase vulnerability and aggravate the impacts of AIDS. Women living with HIV and children orphaned by AIDS are often denied rights to inherit property, leaving them without shelter and without access to care, treatment and economic and educational opportunities. This situation creates new cycles of vulnerability and exploitation. The challenge is to reform legislation in order to reduce vulnerability and protect the rights of women and children, to educate women and communities on their rights and responsibilities with respect to property and inheritance and to ensure that existing legislation is enforced.

B. Promoting gender equality

1. Promoting and protecting the rights of women and girls

13. Social norms that give rise to unequal power relations between men and women reduce women's choices, opportunities and control over sexual relations. Economic dependence on men and inequities in access to information, education, health and legal services limit women's ability to protect themselves from infection. The vulnerability of women to HIV is in many cases a result of the behaviour of spouses or partners. There is an urgent need to involve women and men in addressing social norms that increase vulnerability of women; challenge harmful practices such as early or forced marriage, widow inheritance and female genital mutilation; empower women economically; and provide full access to HIV information and services, including sexual and reproductive health services.

2. Protecting young women

14. The vast majority of young people living with HIV are female, yet social norms frequently discourage education and knowledge on sexual matters for girls. Young women too regularly face exploitation and advances from older men that increase their risk of exposure to HIV. Strategies to address the particular vulnerability of young women are therefore a key priority. The challenge is to ensure that young women have access to HIV and sexual and reproductive health information, prevention methods, and economic opportunities to reduce vulnerability.

3. Ensuring equal access to treatment and care

15. Ensuring that women receive equal access to treatment and care services is a key priority for providing hope, prolonging productive lives, maintaining the integrity of families and lessening the vulnerability of children. Reduced incomes, restricted mobility and greater household responsibilities can leave women with limited opportunities for accessing services, particularly for women living in rural areas. In AIDS-affected families facing economic hardships, it is often men and not women who receive treatment. A key priority is for public health services to provide equitable treatment to women and men in urban and rural communities, and to collect disaggregated data to ensure that services equitably reach those in need.

4. Challenging gender-based violence

16. Physical abuse, coercion and sexual violence are a distressing reality for millions of women and girls across the world, including within homes and schools. Violence and domination heighten female vulnerability to HIV infection. For women living with HIV, violence and threats of abandonment are frequently the response to a positive diagnosis. The challenge is to change the norms of domination and coercion, and promote a rejection of all forms of violence, including through the advancement of the human rights of women and girls.

5. Involving men and boys in championing gender equality

17. Successfully addressing the gender dimensions of the epidemic requires involving men and boys as full partners in championing gender equality and challenging harmful practices. There is a critical need to sensitize men and boys to harmful gender dynamics, to include them as partners in the response to HIV/AIDS and to support the leadership of men who empower women and girls.

C. Reducing vulnerability

1. Reducing the vulnerability of displaced populations

18. Displaced populations, particularly women and children who are displaced as a result of conflict, emergencies or trafficking, are more likely to be marginalized and face sexual violence, exploitation and dislocation from support networks and services. The challenge is to ensure that HIV information as well as prevention, support and treatment services reach displaced populations.

2. Preventing the trafficking of women, girls and boys

19. Trafficking places women, girls and boys in high-risk situations in which decisions about sex are out of their control. Often forced into a form of sexual servitude, they are stripped of their rights to negotiate safe sex or protect themselves from violence, thereby increasing vulnerability to HIV. The challenge is to ensure a rights-based approach that not only addresses the nexus of vulnerability and sexual exploitation but also confronts the burgeoning global business of trafficking.

D. Mitigating social and economic impacts

1. Lessening the burden of care

20. Women and girls bear the added responsibility of providing care and support in families and communities affected by AIDS. This responsibility comes at a high cost, often reducing educational and economic choices and opportunities for women and girls. The pressing challenges are to recognize and support the caregiving roles of women in communities and households, to ensure they have the information and resources required for caregiving and to encourage men and boys to share the responsibility of providing care.

2. Ensuring food security for families affected by HIV/AIDS

21. HIV/AIDS erodes food security as a result of debilitating illness, shrinking household incomes and assets, and increasing the cost of caring for the ill. In families affected by AIDS, women in particular are often forced to abandon or delay farming activities to care for family members or to engage in wage labour to cover medical expenses or purchase food. In other instances, as family members fall ill, households shift from multi-cropping systems that include cash crops, to less labour-intensive subsistence farming, jeopardizing their food security. In addition, gender biases in food distribution can leave women and girls more susceptible to decreased household food availability. A key challenge, therefore, is to implement integrated responses to address HIV/AIDS, food security and gender inequality.

3. Ensuring resources reach women

22. A key area for action is ensuring that resources to respond to HIV/AIDS are targeted at implementing strategies that address the gender dimensions of the epidemic and reach women. There is an urgent need for leadership and political will to ensure that programmes specifically reaching out to women are included in national AIDS strategies and that these strategies are adequately budgeted.

E. Ensuring full participation

Ensuring full participation of people living with HIV/AIDS

23. While the visibility of people living with HIV/AIDS has notably increased at national, regional and global levels, the challenge is to ensure that the development and implementation of HIV/AIDS plans involve the full participation of the women and men who are most directly impacted by HIV. It has been shown that where people living with HIV/AIDS take the lead in the response to the epidemic, the effects are far-reaching and more sustainable. It is thus a priority that networks and

organizations of people living with HIV, including HIV-positive women's groups and networks, be strengthened to facilitate full participation.

IV. Moving from commitment to action

24. Moving from commitment to action and strengthening national and global efforts to improve access to prevention, care and treatment services are priorities for achieving targets set in the Declaration of Commitment. To this end, the key questions to be addressed are what actions must be taken and by whom, in order to:

(a) **Promote bold, forthright political leadership to speak openly about the need to challenge the spread of HIV/AIDS and to ensure that national policies build a compassionate response that reaches and addresses the needs of all affected sectors of society;**

(b) **Eliminate stigma and discrimination and create an enabling environment for protecting the rights of people living with HIV/AIDS;**

(c) **Ensure greater involvement by people living with HIV/AIDS and women in policy and decision-making processes and in implementation and monitoring of programmes (including participation in national AIDS councils, country coordinating mechanisms of the Global Fund to fight AIDS, Tuberculosis and Malaria and implementing bodies);**

(d) **Promote national legislation that protects the rights of women and children and supports governments and civil society taking action to bridge the gap between law and practice;**

(e) **Eliminate all forms of violence against women and girls, including sexual violence, rape and trafficking and challenge harmful practices such as early or forced marriage and female genital mutilation;**

(f) **Protect the rights of vulnerable and displaced populations and enable groups to be reached with information, prevention messages and services to limit the spread of HIV;**

(g) **Promote equal access to treatment and care and ensure that treatment programmes are affordable, flexible and adaptable;**

(h) **Recognize and provide support to caregivers to ensure they have the information and resources to improve community-based care and to lessen the burden of care on women and girls;**

(i) **Actively engage men and boys in challenging harmful gender dynamics, including violence and discrimination, and in sharing the responsibilities of caregiving;**

(j) **Provide all necessary resources to programmes that respond to the specific needs of women of all ages.**